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ABSTRACT

The final report details activities of a 3-year child abuse and neglect program which provided community and professional education about child abuse as well as treatment services (individual counseling, crisis intervention, medical care, and homemaking services). Implementation pproblems and operation issues (including staff turnover and the use of volunteers) are cited. Progress toward six project goals (such as the coordination of community-wide child abuse services) is summarized; project management and worker satisfaction are discussed; and client data is analyzed in terms of client flow, client characteristics, and quality of case management. A final section of the report addresses the project's impact on the community. (CL)

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Final Report 90-C-80

CHILD PROTECTION CENTER: BATON ROUGE, LOUISIANA

I. COMMUNITY CONTEXT

East Baton Rouge Parish is the local government unit encompassing the city of Baton Rouge as well as some surrounding bedroom and rural communities. The parish has a population of approximately 297,000, about 29% of which is Black. Approximately 40% of the population is 17 years old or younger, the age range of children protected by the state's abuse and neglect reporting law. The 1970 census showed 13.6% of the parish families below the national poverty level (as defined by the U.S. Department of Commerce), 20.9% of the families earning over $15,000 a year, and the remainder in the middle-income range.

Baton Rouge, the largest city in East Baton Rouge Parish, is the capital of the state and, therefore, headquarters for the various state agencies. Louisiana State University, the largest university in the state, has its main campus in Baton Rouge, and its Graduate School of Social Work has provided both consultation and job placement referrals to the Center.

II. HISTORY

Until 1972, Louisiana was without a comprehensive law for the protection of abused and neglected children. This did not mean the abuse and neglect problem went undetected, as some parishes had developed procedures for handling reported abuse and neglect in the family courts and a few law enforcement agencies had established special units to respond to such

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cases. Baton Rouge, led by a local pediatrician, played a strong statewide leadership role in promoting greater awareness of the abuse and neglect problem and in advocating a multidisciplinary, multi-agency approach to case handling.

However, concerned individuals and agencies across the state became increasingly alarmed at the lack of a clear mechanism for reporting suspected cases, at the public's misunderstanding about the seriousness of the problem, and at the uncoordinated approach to service delivery. A broad-based advisory committee was organized, and it became the motivating factor behind drafting updated legislation regarding the reporting of child abuse and neglect. The bill, passed in July 1972, required everyone who is a witness to report cases of abuse and/or neglect, and authorized the Division of Family Services (the state's public social service agency) to investigate all reported cases. Concurrent legislation proposed a central abuse/neglect registry and Child Protection Centers in the state's five metropolitan areas. Unfortunately, no funds were allocated to start these Centers, which were meant to provide special referral, investigation and treatment services to abusive and neglectful families.

The problem persisted. In 1973, 16 confirmed cases of abuse and 83 confirmed neglect cases were reported to the State Central Registry for East Baton Rouge Parish and the Parish Sheriff's Department handled 174 "cruelty to children" cases in that 12 month period. Earl K. Long Hospital, Baton Rouge's charity hospital, recorded treating 20 abused and 14 neglected children between January and August 1973.

When news of possible federal demonstration funding came, interested professionals were convened by the State Department of Education, Bureau

of Early Childhood Education, to apply for the grant. This group included representatives from the Baton Rouge Mayor's Office, Earl K. Long Hospital, the Sheriff's Department, the State and Parish Division of Mental Health, the Division of Family Services, the School Board, 4-C's (Community Coordinated Child Care), the Family Court, and Louisiana State University's School of Social Welfare. Support was obtained from the governor on down. The proposal asked for funds to set up a Child Protection Center in Baton Rouge based on the model proposed by 1972 Louisiana legislation. The project would be part of the Division of Family Services, but would be placed in and share staff with Earl K. Long Hospital. To further solidify an interagency approach, the fiscal agent of the proposed project would be the Bureau of Early Childhood Education, also known as the State Office of 4-C's.

III. SUMMARY OF ACTIVITIES

First Year Summary

Following award of the demonstration money in May 1974, the Baton Rouge Child Protection Center was organized. The director, chosen from within the Division of Family Services, was hired in July. She immediately brought in four MSW-level social workers, all of whom were experienced caseworkers, but had just completed their graduate studies. A half-time pediatrician, on the project payroll since July, made up the sixth member of the original staff complement. A public education specialist and a homemaker were added to the staff in September and, after a lengthy search, a supervisor was hired in late October.

The first reports were taken by the project staff in mid-August; most of these were from a backlog in the Division of Family Services' parish office. Word of the new project spread quickly, however, due to a concerted community education effort, and abuse and neglect reports were soon coming from a wide range of sources. With December came implementation of 24-hour coverage for reporting of suspected cases. The social workers began rotating responsibility for being on-call, using a beeper for receiving after-hours reports. A fifth social worker was added in January 1975, but still the project could not adequately serve all new referrals. Therefore, in mid-March an agreement was made with the Protective Services Unit of the Division of Family Services to share intake and treatment, with the project being in charge of abuse cases only and Protective Services handling neglect.

Other significant events during the first year of the project included the initial meeting of the Center's Advisory Board in November 1974. Over 40 representatives of community agencies were present, an indication of wide support for the new project. The Board, which took an active role from the outset, continues to serve as the Center's community liaison. Also, a three-day workshop on the dynamics of abuse was sponsored by the Center in early April 1975. Targeted for professionals in the community, the sessions attracted an average of 90 participants per day.

Second Year Summary

In mid-May, the Center hired a sixth social worker in order to handle the volume of referrals coming in. By the end of May the Center moved into its permanent facility on the grounds of Earl K. Long Hospital. The

mobile unit was expansive in comparison to the temporary quarters which the staff had occupied for more than ten months.

By summer of 1975 the staff were providing some ongoing therapeutic treatment services in addition to the intake and crisis intervention services they had always delivered. Group therapy sessions for mothers and adolescents and couples counseling were the primary modes of treatment offered. Time for provision of treatment was in part made available after reorganization of the staff, which placed two of the social workers into an intake unit with the remaining four in a treatment unit. However, significant staff turnover (without replacement), which began in November and did not end until the beginning of the third project year, necessitated the eventual disbanding of the intake unit and the cessation of most therapeutic treatment services.

Third Year Summary

By June of 1976 the staff, which had shrunk to two workers, had all been replaced and the project operated for most of its third year with a full staff. Therapeutic treatment services were provided to some project clients through referral agreements worked out with the local Mental Health Centers and through a contractual, purchase-of-service arrangement with a private counseling service. Near the end of the third year of federal funding, the project again began providing its own regularized therapeutic counseling to some parent-clients.

The Center's Advisory Board was very successful in 1976 and 1977. Passage of a new state law on termination of parental rights, the development of an emergency shelter care facility for children two years and older, and incorporation as the Baton Rouge Council for Child Protection were

three significant accomplishments.

The public education effort of the Center was expanded in the third year. A team made up of a social worker, a consulting lawyer and the pediatrician, as well as the director and public education specialist, would together make presentations to community groups.

IV. ORGANIZATION/STAFFING

The project grant was awarded to the State Department of Education, Bureau of Early Childhood Development, which acted as fiscal agent and reserved the right to review all project contracts. Bureau of Early Childhood Development staff also provided technical assistance to the Center, particularly in matters of public education, and served in an advisory capacity as the need arose. In addition, the project shared one staff position with the Bureau's local office, the Baton Rouge 4-C's.

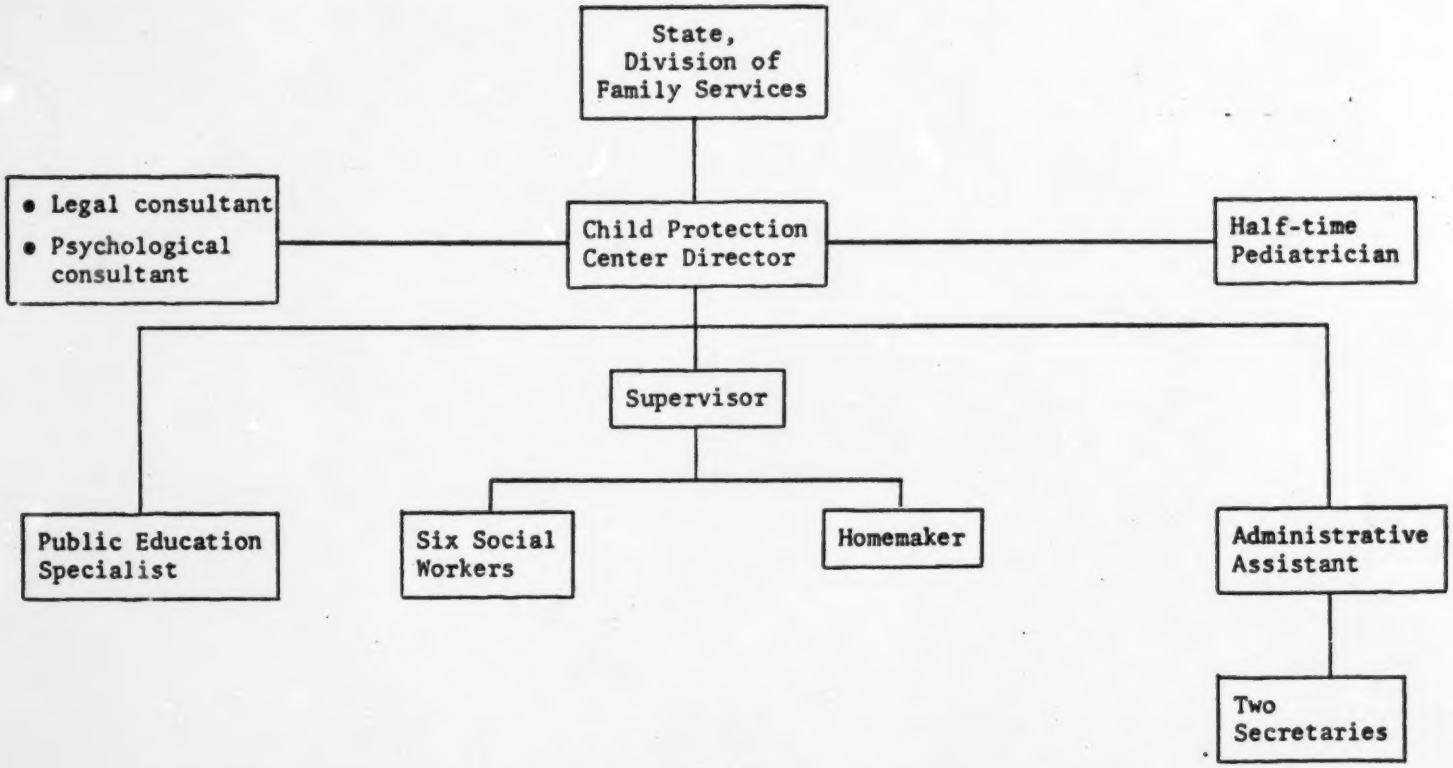
The Department of Education contracted with the state office of the Division of Family Services to operate the project. The Center used the state's reporting procedure for its record keeping and hired through the state civil service system. Also, the project received some funds from the state office; state money paid the salaries of the supervisor and two of the six social workers.

Because of the model mandated by state law, the project was also directly linked to Earl K. Long Hospital. One of the Center staff members, the pediatrician, was housed at the Hospital and the Center's facility was on the Hospital grounds, giving project staff immediate access to Hospital services.

Although the project staff was not technically responsible to the Advisory Board, this group, made up of representatives of various community agencies and interested professionals, provided guidance and direction. The Board, approximately 30 in number, was divided into six committees. Each committee met regularly; the Board as a whole met every other month. The six committees were the Policy Advisory Committee, the Emergency Shelter Care Committee, the Legislative Committee, the Public Awareness Committee, the Resource Committee, and the Comprehensive Emergency Services Committee.

As illustrated in Figure 1, the Center, when fully operating, had three full-time and one part-time staff, and two regular consultants.

Figure 1: Organizational Chart



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V. PROGRAM COMPONENTS

Community Education

The Center's director and pediatrician both were responsible to some degree for representing the project when invited to speak on radio and television or to the various charitable, voluntary, church and professional groups in the community; however, the full-time public education specialist was primarily in charge of the extensive community education effort. In addition to public presentations, a working relationship was developed with the local media which paid off in the form of feature stories, free public service announcements and billboard space. A brochure and information packet about child abuse and the Center's work was widely distributed. Beginning in early 1977, a team of Center staff and consultants began making community presentations, rather than one staff member at a time, as previously.

Professional Education

In the first year, the project's primary professional education effort was provided by the staff pediatrician for Earl K. Long Hospital's house staff. Also, as mentioned previously, a three-day area workshop on the dynamics of abuse was held for people in the fields of social work, medicine, law and law enforcement. In the project's second year, many presentations were made by staff to a range of professionals who requested in-service education and training on child abuse. This ad hoc approach continued throughout the third year, with the exception of a more concerted effort to specifically reach school personnel.

Coordination

After an initial round of visits to a core of agencies that it was hoped would work with the new project, the first Center director then kept in contact with these agencies, either informally, with regard to specific case referral requests, or more formally, in attendance at community-wide policy and planning meetings. During the course of the three demonstration years of the project, several agreements were made to formalize interaction between the Center and other agencies; the School Board, Sheriff's Department, the parish office of the Division of Family Services, the City-Parish Family Court, Earl K. Long Hospital, the two local Mental Health Centers, and the Health Department all made agreements with the Center. Also, during the last demonstration year, a purchase of services contract was worked out with a private family counseling agency whereby the agency would accept a specified number of Center referrals.

Another focus of the Center's coordination activity was its Advisory Board, which provided the Center with a broad base of community support and lobbied for community awareness regarding the needs of abused and neglected children and their parents. In addition, the Board can be credited with assisting in the successful negotiations for emergency shelter placement facilities, which were non-existent in Baton Rouge prior to the project.

Legislation and Policy

People associated with the Center, either as staff or as Board members, were prime movers in promoting the changes in Louisiana's abuse and neglect reporting law that brought the state into compliance with the federal Child Protection Act. In addition, the Advisory Board's Legislative

Committee successfully managed passage of a new state Termination of Parental Rights Act, making it less difficult to initiate and complete the termination process.

Intake and Initial Diagnosis

The project supervisor handled all incoming calls during regular hours, and assigned a social worker to assess the situation further. If the call was urgent, it was automatically given to the worker on call that day. The worker made an immediate home visit and determined any necessary action. If the report appeared to be less severe, the case was assigned to a worker on the basis of workload and expertise in handling certain types of cases. The Center provided 24-hour coverage for the reporting of suspected cases; the social workers rotated this responsibility.

Because of the Center's tie to Earl K. Long Hospital, all children in need of medical attention were brought in by the parents and/or the project social workers and given priority. If it was determined that returning a child to the home might be dangerous, and no emergency placement was found, the child was admitted to the hospital on a short-term basis whether or not such action was medically necessary.

Complicated cases, those taken through the court or those involving several people and agencies, were addressed at multidisciplinary dispositional conferences held once a week. These meetings brought together Center staff as well as consultants who suggested a diagnosis and recommended a plan of action.

Case Management

The six social workers were responsible for providing or arranging for the services that clients needed to facilitate stabilization of their lives, such as day care, food stamps and other public assistance. If cases were determined to need court intervention, then reports and testimony were prepared. All cases in the ongoing caseload were reviewed periodically with the Center supervisor; if the case was particularly difficult, a staffing was held.

Treatment

Individual Counseling: most regular ongoing counseling for Center clients was provided by referral, either at a Mental Health Center or at Family Counseling Services, under contract to the project. Center social workers also provided counseling for some clients who required only short-term treatment.

Crisis Intervention: most contact with clients, once the intake process had been completed, the family situation stabilized, and necessary support services or counseling arranged, came at times when new family crises arose. The social workers, available to their clients at all times, responded immediately to critical situations and provided the necessary advice, support and referral until the crisis had passed, thereby attempting to prevent potential reabuse.

Medical Care: the project's proximity to and special relationship with Earl K. Long Hospital meant that medical care for children of clients could be easily arranged. The project's pediatrician provided any necessary medical attention.

Homemaking: the homemaker was a vital part of the Center's services from the outset. She filled two roles: for some families she provided one-time-only assistance in the form of babysitting or transportation to appointments; however, her most important function was that of a friend and advocate to those families with whom she worked for several weeks or even months. For ongoing cases, she visited the home once or twice a week, helping with household activities and acting as a teacher and role model for mothers who were not able to cope with their situations.

VI. IMPLEMENTATION/OPERATION PROBLEMS

Implementation Issues (First Year)

Defining the caseload: at first, it was planned that the Center would provide services to all abuse and neglect cases in the parish. The project was to carry out intake and keep clients in treatment for a short term (about three months). It was expected that in that time, the clients' lives would have become stabilized and the cases could be transferred to the Protective Services Unit for limited services and monitoring. However, after the Center began taking clients, it became clear that the initial four social workers could not handle all the referrals and also provide ongoing direct treatment. Moreover, it was not feasible, in most cases, to keep clients for only three months, since the worker needed this amount of time just to begin establishing a trusting relationship with the client.

Several alternatives were considered: (1) the Center could reorient its work toward intake and crisis intervention only and cases could be moved to the Protective Services Unit as soon as possible, thereby allowing a faster turnover of cases; (2) the Center could ask the parish office

of the Division of Family Services to verify all instances of suspected abuse and neglect identified in its caseload before the cases were referred to the project for intake; (3) a volunteer program could be started to provide more assistance in working with clients; (4) the staff could be increased; or (5) the parish Protective Services Unit could alleviate the caseload burden by handling neglect cases while the Center handled only abuse.

Over time, the project managed the demand with a combination of some of the alternatives under consideration. A social worker was added when the caseload became overtaxing. When that action proved inadequate, an agreement was worked out with the Protective Services Unit whereby it began taking neglect cases again -- after the state office of the Division of Family Services promised the Unit additional workers. And finally, project-provided therapeutic services were curtailed and referral arrangements to outside agencies for such services set up.

Hiring a supervisor: the original proposal's budget did not call for a casework supervisor; consequently the project director initially assumed this role in addition to her other responsibilities. Since the number of cases rose appreciably in the first two months, the director was inundated by the workload and saw the impossibility of maintaining a dual role. She immediately requested funding for a supervisor position, and because it had not been budgeted originally, Division of Family Services funds had to be used. In retrospect, it was thought that if the project had not begun accepting referrals until after the supervisor had been hired, the inefficient handling of cases during the first few months of the project's operation could have been prevented.

Heavy workload: the Center's public education and information effort was extremely successful, due, in part, to having a full-time public education specialist on the staff. The intense level of educational activities led to a large number of cases per worker almost from the beginning and, even with the addition of new workers, the caseload reached 28 cases per worker in March of 1975. This caseload size was contradictory to the project proposal which called for no more than 20 cases per worker, in order to allow time for ongoing treatment and 24-hour coverage. Heavy use of the after-hours service added to the workload. The workers expressed concern that they were not adequately compensated for the restrictions and disruptions 24-hour duty caused in their lives. Frustration caused staff morale to drop to a point that changes had to be made. The project began taking abuse cases only and added a sixth worker, to share the cases and the 24-hour coverage. And, the state was finally convinced to provide more liberal compensation for night and weekend on-call work.

Temporary facilities: from its inception the project had intended to be housed at Earl K. Long Hospital. When it was learned that the planned facility would not be available, a temporary place was found at area office of the Division of Family Services. The temporary offices proved to be a continuous source of strain because was inadequate, with all social workers crowded into one large room and, by the third or fourth month, the staff had a sense of overstaying its welcome. Lack of space also meant lack of privacy for client interviewing, which impeded open communication between caseworker and client. Red tape at the state level and complicated state building codes delayed the move until May 1975.

Lack of child placement facilities: from the outset the project faced a lack of placement facilities for children. There was no emergency shelter care and the supply of foster homes and day care facilities was inadequate. Although the Foster Care Unit of the Division of Family Services is responsible for maintaining an adequate number of foster homes, the Center had difficulty in getting more than a few placements. Earl K. Long Hospital served to ease the situation somewhat through its agreement to keep children in the hospital until placements were found, even though their stay was not medically required. The project, through its staff and Advisory Board, finally alleviated this problem to some extent by bringing it to the attention of the community and searching for appropriate sponsors and facilities.

Coordination with key community agencies: The parish office of the Division of Family Services during the first year of project operation had a strained relationship with the Center. Speculation about the causes of this tension included the following: traditional methods of bureaucracy being disturbed by the new project, with its special attention and experimental status; a sense of competition arising from the Center being under the direct jurisdiction of the state office of the Division of Family Services instead of the parish office; and/or the project not agreeing to handle cases of abuse and neglect when the workload exceeded the 20 cases per worker stipulated by the grant, a luxury which the parish office staff had never had. The Foster Care Unit of the parish office was particularly resistant because the Center placed increased demands on their limited number of foster care homes. Over time, the relationship improved due to continuous communication between the Center and the parish office.

Working with the Baton Rouge schools was also difficult during the first year. After a round of presentations by Center staff to school administrators, it was discovered that information was not disseminated to the classroom teachers, who are vital reporting sources. Teachers expressed reluctance to report suspected cases; some believed reporting would jeopardize their relationship with the parents, and others believed the project was ineffectual when it did not always have the reported child removed from the home. Besides the problem of failure to report cases, the lack of trust on the part of the schools was an issue that the Center had to address. Direct education of classroom teachers became a priority. By the end of the initial year of the project, an agreement with the School Board called for classroom teachers to report to visiting teachers (school counselors) on suspected cases and the visiting teachers would report to the Center.

Operation Issues (Second and Third Years)

Use of volunteers: during the first year the Center accumulated names of people who had volunteered their services. After the project's program was well underway, it was decided to organize the volunteers. Several weekly orientation meetings were held, individual screening took place isolating the specific interests of each volunteer, and then intensive training was carried out. However, using volunteers effectively proved to be difficult. Every social worker was given a list of names and phone numbers, but they soon found that most of the volunteers worked during the day and were not available when it was most critical or on short notice. Further, the type of work that the volunteers seemed to prefer, i.e., playing with children, was not as critical as some of the

other tasks which the social workers had identified as appropriate to their needs. It became apparent that a large amount of paid staff time was necessary to successfully coordinate and define roles for volunteers, and without this support, volunteer assistance ceased by the middle of the second year. The Center hoped that there could be a useful role for volunteers, but a new, concerted effort would be required to use them effectively.

Staff turnover: loss of staff in the second year left a major void in the project's operation. Two of the social workers left in November 1975, the director left in December of that year, the supervisor who was also acting director left in March of 1976, and two other social workers left in the spring. All of these staff losses were without replacement for an extended period. Lack of staff led to several restrictions, including a moratorium on community public relations and education because there was not enough staff to handle referrals generated by these activities. Also, the social workers, drained from handling crises and intakes, could no longer provide ongoing therapeutic treatment, and these activities stopped. The shortage led to the closing or transferring of many cases (possibly prematurely), with the remaining two social workers and supervisor carrying very large caseloads. The state office of the Division of Family Services and the State Civil Services Board were reluctant to make exceptions in hiring requirements (credentials, experience or salary level) and, therefore, it was not until spring of 1976 when the Louisiana State University School of Social Work graduated a new class that there were people who met the job qualifications as well as were willing, because of a tight labor market, to accept the positions.

Provision of treatment services: during the last project year, particularly with the filling of all staff positions, there was pressure on the staff to resume provision of regular treatment services. The major problem was a lack of on-site space for treatment sessions, although this would change with the planned move to new, larger offices. In the meantime, referral arrangements for counseling were made with a private agency, as well as with a private psychiatrist. Some staff believed that crisis intervention and limited individual counseling, in addition to thorough intake, was all that the Center could and should provide, while others were pushing for freeing up time from intake and other responsibilities in order to begin to see clients for regular, therapeutic treatment.

VII. FUTURE PLANS

The state Division of Family Services committed funds for the continuation of the Child Protection Center beyond the expiration of federal funding. Since the Center in Baton Rouge is one of several such programs throughout the state, it is no surprise that it is being maintained in close to its present form. Only one staffing change occurred due to more restrictive budgeting -- the public education specialist position was not picked up.

The major unresolved issue, however, is administrative responsibility for the Center, presently directly under the state office of the Division of Family Services. While there had been some moves in the past to place the Center under the Division of Hospitals, the umbrella agency that operates Earl K. Long Hospital, the real pressure has been to move jurisdiction to the parish office of the Division of Family Services. Strong

opposition has developed to this proposed change in affiliation, but a final decision has not yet been made.

VIII. PROJECT GOALS

Goal 1: To provide expeditious intervention for and disposition of child abuse referrals.

Overall, in the first year of the project considerable gains were made toward reaching this goal. First of all, criteria for the type of intakes accepted were worked out. Developing a smooth working relationship with its host institution, Earl K. Long Hospital, was another step that the project took to facilitate response to abuse reports. Provision of 24-hour coverage for incoming reports also contributed to efficient and effective intake. The final action that the project undertook towards specifically meeting this goal was to set up a mechanism for multidisciplinary dispositional conferences. By the fall of 1975, 90% of the referrals were responded to within 24 hours and the entire intake process, including psychological evaluations and dispositionals, were completed in three to four weeks for more than 80% of the cases.

By the end of the second year, due to the severe staff shortage, it was clear that the project was almost no further ahead in terms of providing expeditious intake than at a point just four or five months after the beginning of operation. Response time to referrals and the length of time to complete intake fell off markedly. However, at the beginning of the third year all positions were filled and new staff oriented and trained. This meant that the project again was checking on referrals promptly and completing most intakes in less than a month.

Goal 2: To improve client functioning by developing a variety of treatment approaches for child abuse.

Soon after the project successfully set in motion its investigation and intake procedures it began to establish several treatment services aimed at abuse clients. It was to be the implementation of innovative direct treatments, along with the multidimensional intake process and the community and coordination activities, that would serve to distinguish this as a demonstration project.

Over a several-month period during the first project year, some treatment services were introduced, but for the most part these services were used for only a limited number of clients and, at the end of the demonstration period, the project staff was providing no therapy except individual counseling. The project provided, however, since its beginning a useful and successful support service to many of its clients, that of homemaking. The homemaker served as a key resource to families in need of household management assistance and/or respite from child care.

Goal 3: To foster coordinated community-wide child abuse services.

The efforts on the part of the project's director, during the initial months of operation, to incorporate the Center into the existing abuse services network and to expand the service resource network paid off in terms of improving communication among the various agencies. Establishing procedural protocols with some key agencies, and regular attendance by project staff at meetings to encourage the development of new community resources contributed toward a more coordinated system.

The lack of administrative leadership during the second project year meant little of the necessary follow-through for maintaining the coordinative arrangements set in motion, so that some working relationships

never really took effect in practice or, if they did, they began to break down. However, some of the results of the early coordinative work did last, particularly as evidenced by the effective functioning of the Center's Advisory Board. And, with the addition of new staff in the third year, renewed efforts developed new resources for abuse clients, including emergency shelter care facilities for children two years and older, an expanded referral agreement with the Mental Health Centers, and a purchase-of-service arrangement with a private counseling service.

Goal 4: To integrate physicians and certain other professionals into the child abuse services system by directing education efforts toward these targeted groups.

Following a three-day workshop in April 1975 for the Baton Rouge professional community, the project took steps toward organizing a concerted effort to reach certain groups, i.e., physicians, school personnel (primarily teachers) and law enforcement officers. The project's second year refunding proposal set out a detailed plan to reach the physician community by approaching them through their professional organizations and through the private hospitals, particularly through emergency rooms. A systematic approach for reaching schools was also spelled out.

Again, due to staff shortages during the second year, actual organized implementation of the professional education component was held up. While the targeted professional groups were not contacted as planned, there was always a willingness on the part of project staff to respond to all requests to make presentations at symposiums, professional meetings, other agencies' in-service training and to students in professional training.

In terms of impact, private physicians were still, for the most part, operating apart from the rest of the child abuse service system. With the other targeted professions -- school personnel and law enforcement officers -- more progress was noticed in terms of their understanding of child abuse and the project's role in handling reports.

Goal 5: To develop training programs for greater community awareness and understanding of the dynamics of child abuse and of child rearing in general.

A full-time public education specialist, plus other project staff, spent a significant amount of time in working toward achievement of this goal. It is always difficult to determine the real outcome of these education efforts in terms of greater awareness and knowledge on the part of the community. Certainly, personnel in the various abuse-related agencies throughout the parish perceived that the general public was more aware in 1977 of the child abuse situation and how to respond to a case of suspected abuse.

Another method for looking at achievement of this goal (i.e., actual new awareness and understanding of abuse) is increase in reporting from the general community. Between 1974, when the project began its education, and 1976, reports from relatives, acquaintances and anonymous persons to the project and to the Protective Services Unit increased from 52 reports in 1974 to 153 in 1975, and then fell slightly to 134 in 1976. From these data it appeared that the general public in Baton Rouge became more aware of child abuse and where to report.

The project did not carry out any planned activity toward changing or improving child rearing practices in general, a stated focus of part of this goal.

Goal 6: To improve the project's internal management and support the community need for additional services by gathering and maintaining program statistics.

During most of the demonstration period, the project supervisors, already inundated with other responsibilities, were the only persons maintaining program data. While only minimal information was collected to support achievement of this goal, at least one change was effected based on collection and assessment of service statistics: data on need for shelter care was used by project management and the Advisory Board to pressure the state into contracting for emergency placement beds. Toward the end of the demonstration period, maintenance of client data was delegated to one of the social workers, who made plans to use the information for program planning purposes.

IX. PROJECT MANAGEMENT AND WORKER SATISFACTION

Description

The Child Protection Center was a relatively small project with a full-time staff of 13 workers. It served an average caseload of 83 clients with an average monthly budget of $13,906.

The organizational structure of the project was not complex. There were only four different professional disciplines involved in the program activities: social workers, an attorney, a doctor and a psychologist. A moderate level of diversity characterized the project's activities, which included professional and community education, coordination, and case management responsibilities.

The project was highly formalized in that the staff were held accountable by the state civil service system for procedures and policies related to recruitment, employment and promotion. The project itself operated fairly informally, e.g., there was no rule manual that defined how the staff members were to relate to each other. Rule observation was relatively lax.

The project was highly centralized, under the direct supervision of the Division of Family Services, which was ultimately responsible for program and policy decisions. However, the project operated fairly autonomously because it was supervised by the state office of the Division of Family Services as opposed to the local parish office. The state office had less time and motivation to monitor the project staff than would have been true of the local parish office.

Satisfaction

There appeared to be a high degree of ambivalence among project staff regarding the project management and their own job satisfaction. In the management survey, staff reported moderate to high rankings for most of the management dimensions, that is, leadership, innovation, peer cohesion, staff support, autonomy, task orientation, clarity and communication. Although 83% of the staff reported high overall job satisfaction on the written questionnaires, in individual interviews workers stated they were highly dissatisfied with many aspects of their jobs, i.e., the state bureaucracy, the project leadership, and the pressure and stress of working with abusive parents. The project's 62% turnover rate and the staff's reported burnout rate (40% high burnout, defined as those falling in the bottom one-third of an administered "burnout scale") seem to verify that

many workers were unhappy with the project and their jobs.

Some of the workers' ambivalence about the project could be explained by the particular characteristics of this project staff. For many of the workers, employment in the project was simply a substitute job until opportunities were available in other specialities (e.g., medical social work, planning, juveniles). The project met their immediate needs and was "ok," but never really satisfied their interests and expectations. For other social workers, the project offered an opportunity to gain work experience and be eligible for promotional opportunities in more desirable state jobs. Most of the social workers reported that they did not believe anyone could work with abusive parents beyond a year and a half. They accepted the job knowing that they would leave or burn out in a year.

Management Issues

In addition to the staff characteristics there were a number of management problems that contributed to and speeded up burnout and turnover among project staff. The majority of the workers were recent MSW graduates with new professional values and expectations. The project was their first job out of school and they were struggling against the state bureaucracy and limitations in the system. The battle produced substantial disillusionment with the state, project and clients.

The project's biggest problem with the bureaucracy occurred during the first year. In order to implement 24-hour coverage, develop coordination and referral agreements, and provide community education, many of the workers reported working over ten hours a day. They felt that the state should reimburse them for this excessive overtime. The staff's initial requests were ignored. Finally, the workers filed a formal

grievance, and after some delay were given an official agreement on overtime compensation.

Another problem the staff experienced with the civil service system occurred in the second year. Because the state never communicated clearly its civil service and hiring procedures and because of system errors, workers employed during the second year on emergency appointments were not placed on the official job registry and therefore were unable to collect overtime compensation, were bypassed for raises and workers' benefits, and were required to take several state tests. The most frustrating aspect for the workers was that they never had the correct information to negotiate for their own rights effectively. Some of these newly hired workers remained with the project only about four months, leaving as soon as they had located jobs in other community agencies.

Internal staff dynamics also served to limit the project's effectiveness during part of the second and third years. After being with the project a little over one year, the project director accepted a promotion to the state office. Most staff by that time were beginning to feel strain from their work. Most had been in graduate school together and had developed a comaraderie that both enhanced and was detrimental to their work experience. The workers who also socialized together found themselves talking about project and clients all the time and they began to identify more with each others' work crises than with the clients who were in crisis. The staff had made a commitment to each other and to the director to work with the project at least two years, but when the director announced that she was leaving, others interpreted this as permission to leave also.

The supervisor was appointed acting director and was required to do both administration and supervision until the director's position could be filled. Unfortunately, the state office was unable to find anyone who wanted the director's job and would not appoint the acting director because of a civil service technicality. No one in the state system wanted the job because of the expected workload and because the staff were reputed to be demanding.

The acting director left within months, discouraged with the dual job stresses and the unresponsiveness of the bureaucracy. Most of the remaining workers followed suit and only two social workers were left by May 1976. For nearly six months all regular treatment services were discontinued and the project was severely crippled. Finally, in response to pressure from the funder, the state began to assume a more active role in recruiting staff. By this time the new class of MSWs had graduated from the local university and were willing to work in the project. In the meantime a supervisor from the State Juvenile Shelter applied for the project director's position. The project was completely restaffed by August 1976.

The new director, with limited child abuse experience, was not given any orientation to the project or staff, and did not receive any training for the position. When he took the job, he and the remaining staff members who had stayed with the project from the beginning and who had helped manage the program since the acting director left in March, did not have a clear idea of what his role and responsibilities in the project were. Consequently, the staff and the project director were soon in conflict. There were formal weekly staff meetings, but no one was willing to broach the topic of staff discomforts. Instead, workers often spent many hours

venting complaints; energy needed for serving clients was displaced on the internal project conflict. There was no one in the project or in the state office who was willing to facilitate the resolution of the staff difficulties. Consequently, staff turmoil interfered with project productivity. Even after the project was fully staffed, most of the innovative treatment programs were not reinstated, client crises became more debilitating to workers, and they felt continuously overworked.

X. ANALYSIS OF CLIENT DATA

Client Flow

The prospective client first came to the attention of the Center through reports from one of several sources, primarily law enforcement agencies, the parish office of the Division of Family Services, and schools. Neighbors and relatives also reported many suspected occurrences of abuse. All incoming phone calls went to the Center's supervisor and he or she recorded essential information about the nature of the complaint and the source of referral, and then attempted to sort out the validity and seriousness of the complaint. Calls from agencies were routinely investigated, but calls from individuals were screened over the phone, weeding out those that involved family or neighborhood altercations or were otherwise inappropriate for the project caseload. Situations that appeared to be strictly neglect cases were referred to the Division of Family Services, since the Center handled only abuse cases.

If there was any doubt about the validity of a referral, the supervisor sent the social worker on-call that day to investigate the matter.

When the report appeared to be urgent, a worker responded within 24 hours; otherwise, up to two weeks or more might pass in some instances before an initial contact was made. The intake investigation involved a home visit in order to talk to the alleged abuser and, to the extent possible, to the rest of the family. Others, including the reporting source, also might be interviewed for pertinent information. If the social worker believed the abused child was in immediate danger, the child was taken out of the home, most often to Earl K. Long Hospital for examination and a temporary "hold." If the family needed financial, legal or health and welfare assistance, the appropriate advocacy services were arranged while intake was in progress. For many clients, psychological examinations were also scheduled.

Depending on the complexity of the case and the number of other agencies involved, the diagnosis and treatment planning process could take two or three weeks. As mentioned earlier, consultants were called upon when a case necessitated either legal or psychological advice and a multidisciplinary review might have been held if so warranted.

The court became involved if change of custody was recommended for the abused child(ren). If the court ordered foster care, the entire case was transferred to the Foster Care Unit of the Division of Family Services.

In addition to case management and individual counseling, the Center itself offered homemaking for clients. Referral for treatment could also be arranged. Cases were reassessed periodically at a meeting between the social worker and supervisor. Length of treatment depended on the positive changes in the family situation.

Termination from the project took two forms. If the social worker and supervisor agreed that no more services were necessary or if a client

moved from the parish, the case was closed; if some monitoring of the family was considered important, the case was transferred to the Protective Services Unit of the Division of Family Services. No formal follow-up procedure had been adopted, but terminated clients were reminded about the project's 24-hour coverage and were encouraged to contact the Center whenever they needed assistance.

Client Characteristics

The description that follows of the project's caseload is based on data from cases that were both substantiated and accepted for ongoing services. This means that the picture presented here does not include those cases that, after investigation, were found to be unsubstantiated, those for which intake was not completed, and those that were open a month or less.

The largest source of reports to the project by far were from schools (27%). Law enforcement agencies, hospitals and relatives were the next most common reporting sources; 18%, 17% and 16%, respectively. Only 2% of the cases were self referrals.

Almost half (49%) of the Child Protection Center cases involved physical abuse alone, with another 14% involving sexual abuse. Comparatively, the relatively small percentage of physical neglect, emotional maltreatment and potential abuse or neglect cases reflects the project's evolving acceptance criteria, from taking all abuse and neglect cases initially to limiting their intakes to physical or sexual abuse only. In looking at the project cases in another way, 27% included assault (that is, severe or moderate abuse and/or neglect, including sexual abuse).

The mother or mother substitute was responsible for the maltreatment 50% of the time, with the father responsible 35% of the time, and both father and mother liable in 13% of the cases. No legal action was taken in 25% of the cases; however, formal court hearings were held 10% of the time. Reports to another mandated agency occurred 21% of the time and to the Central Registry 30% of the time. Seventy-nine percent of the cases had no record of previous abuse or neglect before being reported to the project.

For 28% of the project's cases only one adult was in the household. The average client family had 2.6 children and 66% of the families had preschool children (six years or younger). The project families had a low level of education; 73% did not have even high school degrees represented. In 59% of the cases there were no ethnic minorities in the families, while in 31% of the cases there were no employed adults in the household. Whereas 57% of the families had incomes under $5500 per year, only 28% of the families were on public assistance. The average age of the mothers in caseload families was 30 years and the fathers 33 years. In 45% of the cases there was at least one teenage parent.

The most prevalent problems in the household leading to maltreatment of the children were financial, marital, and continuous child care responsibilities. Job related and mental health problems also appeared relatively important as contributors to child maltreatment.

Table 1
Client Characteristics

Source of Referral

Private physician	2%
Hospital	17%
Social service agency	11%
School	27%
Law enforcement	18%
Court	1%
Parent	5%
Sibling	0
Relative	16%
Acquaintance/neighbor	8%
Self	2%
Anonymous	5%
Other agency	3%

Type of Maltreatment

Potential abuse or neglect only	9%
Emotional maltreatment only	6%
Sexual abuse	14%
Physical abuse	49%
Physical neglect	18%
Physical abuse and neglect	4%

Severity of Assault

Not serious	73%
Serious	27%

Responsibility for Maltreatment

Mother	50%
Father	35%
Both	13%
Other	3%

Legal Actions Taken

None	25%
Court hearing	10%
Reported to mandated agency	21%
Reported to central registry	30%

Previous Record/Evidence of Maltreatment

None	79%
Previous record/evidence	21%

Demographic Information

Average number of children in family	2.6
Families with preschoolers	66%
Families with one adult	28%
Families with no high school degree	73%
Families with no minorities	59%
Families with no one employed	31%
Families with less than $5500 per year	57%
Average family income	$7,400
Average age of mothers	30 yrs.
Average age of fathers	33 yrs.
Families with teenage parent	45%

Problems in Household Leading to Maltreatment

Marital	41%
Job related	24%
Alcoholism	8%
Drugs	2%
Physical health	16%
Mental health	24%
New baby	11%
Argument/fight	18%
Financial problems	46%
Mentally retarded parent	5%
Pregnancy	2%
Heavy continuous child care	39%
Physical spouse abuse	10%
Recent relocation	16%
Overcrowded housing	11%
Abused as child	16%
Normal method of discipline	14%
Social isolation	15%

(N=131)

Quality of Case Management

The information collected for the case management assessment indicated that the project provided, in most instances, better than average intake compared to the norm of all the demonstrations combined. Thirty-three percent of the cases sampled for the assessment were contacted within the same day as the report; an additional 24% were contacted within three days. However, 19% of the cases reviewed were not contacted until over one month from the date of the incoming report. Many of the cases not responded to until over a month later turned out to be suspected mild neglect reports that had been trasferred all together to the project early in its operation, after being backlogged at the Protective Services Unit -- they continued to be backlogged at the Center. Thirty-eight percent of the sampled cases showed at least one additional contact with the client before a treatment plan was completed, and a full 50% had two or more such client contacts. This compares favorably with the norm across the demonstration projects of 42% of the cases seen two or more times after the initial contact before a treatment plan was determined.

In 61% of the cases reviewed, treatment services began within two weeks of the first contact between project and client. On the other hand, a full 25% of the clients received no therapeutic treatment services at all. A portion of the project's cases were formally assessed and reassessed, either by a multidisciplinary review team and/or staffings; 27% had at least one multidisciplinary team review and 42% were reviewed in case conferences or staffings at least once. For one-third of the reviewed cases, an outside consultant (e.g., lawyer, psychologist, etc.) was used. There was only minimal direct client participation (7%) in the case management

process, as measured by client presence at a multidisciplinary review or a case conference.

For 84% of the cases, the primary case manager interviewed for the assessment also carried out the intake. This reflects the fact that the project's intake unit was short-lived. Whereas 32% of the clients had no other project staff member working with them besides the case manager, the remaining 68% did. In most cases this meant that the project's homemaker was one of the other project staff members assigned during the course of treatment and often the project supervisor provided temporary counseling and crisis intervention to clients as well as the case manager. Some short-term therapeutic groups also included some of the clients. Of the clients in the sampled cases, 64% were also receiving services from outside agencies. Of these, there was evidence of communication with these agencies regarding the client and his/her progress 93% of the time.

Twenty percent of the project's cases were active for three months or less. About two-thirds were open 4-12 months, and 13% were open between 1-2 years. Following termination, in 56% of the cases at least one follow-up contact was made either with the client or with another agency from which the client was receiving services.

Table 2

Case Management Characteristics*

Time Between Referral and First Client Contact

Same day. 33%
1-3 days. 24%
4-7 days. 9%
Within two weeks. 9%
Within one month. 6%
Over one month. 19%

Number of Client Contacts (after initial contact) Before Treatment Plan

None. 13%
One 38%
Two 13%
Three-five. 30%
Over five 7%

Time Between First Client Contact and First Treatment Service

Within two weeks. 61%
Two weeks to one month. 3%
Over one month. 11%
No treatment given. 25%

Use of Multidisciplinary Review Team

At least one review 27%
Review during intake. 4%
Review during treatment 22%
Review at termination** 0

Use of Case Conferences (staffings)

At least one conference 42%
Conference during intake. 20%
Conference during treatment . . .24%
Conference at termination** . . .16%

Use of Consultants

None. 67%
One 13%
Two 2%
Three-five. 11%
Over five 7%

Client Participation

Client presence at MDT's and/or case conferences 7%

Contact with Referral Source

For background information. . . .84%
For progress reports. 49%

Responsibility for Intake

Current case manager. 84%
Other staff member. 16%

Number of Case Managers

One 87%
Two 13%
More than two 0

Reason for Two or More Case Managers

Joint management. . . . . N= 1
Staff turnover. . . . . N= 2
Staff unavailability. . . . . N= 3
Lack of success with client . N= 0
Other . . . . . N= 3

Number of Treatment Providers in Project (other than case manager)

None. 32%
One 27%
Two 21%
Three-five. 20%
Over five 0

Services from Outside Agencies. .64%

Evidence of Communication with Outside Agencies. 93%
N=28

Frequency of Contact by Case Managers

Once per week or more 36%
Once or twice per month 22%
Less than once a month. 2%
Once or twice only. 4%
Varied over time. 33%
None. 2%

Table 2 (continued)

Follow-Up Contacts**		Length of Time in Treatment**	
At least one contact (client/ other agency)	.56%	Through three months	.20%
Two or less (with client)	.93%	4-12 months	.67%
Three-five	4%	1-2 years	.13%
Over five	2%	Over two years	0

*Throughout, percentages may not sum to 100% owing to rounding.

**Terminated cases only.

Total cases reviewed = 45; total terminated cases reviewed = 45.

XI. COMMUNITY IMPACT

Summary

Many positive changes have taken place in the Baton Rouge child abuse and neglect service system since the project began. Three of these changes, however, are most noteworthy. First, a new level of awareness about the magnitude of the abuse and neglect problem led to increased coordination among personnel of the various agencies and to a doubling of the staff in the local Protective Services Unit. Second, the provision of 24-hour crisis intervention by the demonstration project staff provided the general public and certain reporting agencies (hospitals and law enforcement, primarily) immediate access to assistance from trained social workers. The extensive use of the 24-hour call system (25 to 35 calls per month) proved that the service was meeting a tremendous need. And finally, the project's affiliation with Earl K. Long Hospital helped ensure that medical care was provided to many children who otherwise would not have received it.

Some community-wide problems still need to be resolved before the service system can become fully effective. The most important are the following: the private medical community has not yet met its responsibilities in reporting suspected cases; the project needs ongoing support from the state office of the Division of Family Services for maintaining adequate staff capacity; and the Mental Health Centers and the private counseling agency which accept project referrals have not yet worked out an adequate treatment approach for working with abuse and neglect clients.

Community System Operations

A spirit of informal cooperation among the key agencies characterized the community abuse/neglect services in Baton Rouge prior to the federal funding of the Child Protection Center. The system was not centralized around a single agency, but instead some of the key agencies and institutions had evolved a division of responsibilities. Prior to the passage of the 1972 reporting law, the Probation Department of the City-Parish Family Court had the responsibility for handling abuse and neglect cases. In the late 1950s already the Court had worked out an agreement to have the Sheriff's Department conduct the initial investigation on severe cases. With the implementation of the 1972 state reporting law, the Court divided responsibility for abuse and neglect cases with the Division of Family Services; the Court handled those families that did not qualify for public assistance and the Division of Family Services, Protective Services Unit, handled those who were public assistance recipients. The Family Court was also responsible for filing petitions regarding removal of children from the home. Most petition requests originating from outside the Probation Department came from the Division of Family Services.

In addition to homemaker services, the Protective Services Unit of the parish office Division of Family Services provided traditional protective services: investigation, counseling and advocacy services. This unit was very short-staffed for the volume of cases reported and, therefore, following the delivery of services during a family's crisis period, the case was transferred for maintenance to the regular welfare services staff. Foster care was and still is under the jurisdiction of the Division of Family Services. All cases that require placement of the child(ren) when a willing relative or friend cannot be found, are automatically transferred to the Foster Care Unit for ongoing case management and services.

Law enforcement agencies are one of the mandated agencies to which the public can report suspected abuse and neglect, and before the inception of the project, the East Baton Rouge Sheriff's Department was the agency receiving most initial reports in the community. Publicity efforts had encouraged the public as well as other police departments to make referrals to the Sheriff's Department and its Child Abuse Team, which had developed a reputation for effective handling of suspected cases. Their policy was to conduct immediate investigations, but then to call in either the Division of Family Services or the Family Court workers.

The city's private hospitals and physicians were very uninvolved in the abuse/neglect services system. However, Earl K. Long Hospital, the local public (charity) hospital, became a leader in the community in providing services. The Chief of the Pediatrics Department at the Hospital was primarily responsible for bringing the problem of abuse and neglect to the attention of the state leadership. He aided in the upgrading of

the local service system by developing and urging implementation of the shared responsibility services model which was in effect prior to the Child Protection Center. Total house staff participation in in-service training on recognition of child abuse and neglect, a bi-weekly Pediatric Family Clinic which provides regular follow-up to all hospital-identified abuse and neglect cases, and a policy of providing temporary shelter for children until alternative placement can be found are evidences of the Hospital's commitment to abuse and neglect services.

Before the demonstration project began, school personnel were isolated from the abuse/neglect services network. Visiting teachers, a special unit handling truancy, were responsible for dealing with abuse and neglect cases discovered in the Baton Rouge schools, although most were not aware of the scope of the problem. These teachers worked with school nurses and social workers in deciding how to proceed in alleviating any situation that arose. If it was decided that a child was seriously endangered, a referral was made to either law enforcement, Protective Services or the Court.

Other community service agencies were also removed from the main delivery system. The two Mental Health Centers and the East Baton Rouge Health Unit (the parish public health department), with resources to accomodate individual case referrals from the Court or Protective Services, were not knowledgeable about the dimensionz of the abuse and neglect situation. These agencies had no special programs for abuse and neglect, and with minor exceptions, were not a source of reports of suspected cases.

The state has a Central Registry which began keeping abuse and neglect reports in March of 1973. The Registry uses the American Humane Association's reporting form and was originally set up to enable protective services workers to track repeat abusers who were moving around the state. However, little use has been made of it for disposition of individual cases; instead, the Registry data serve primarily as a program planning tool for the Division of Family Services.

Over its three years of operation the project became the focal community agency for the handling of abuse cases. Originally, it was planned that the Center would provide parish-wide intake and short-term services (three to six months) for both abuse and neglect cases, but this proved impossible given the ever increasing volume of reports and the limited staff. Therefore, in exchange for increased state funding to fill three more Protective Service slots, the parish office of the Division of Family Services agreed to take all reports and deliver ongoing services to child neglecting clients while the Center would provide those services for child abusing clients. There were, thus, separate entry points into the system, depending on whether the case was one of abuse or neglect. The other abuse/neglect service agencies had been alerted to this shared role, and for the most part referred appropriately; the general public was given the Center's phone number for reporting purposes, but the Center staff then referred all neglect reports on to Protective Services. Both the Protective Services Unit and the project used day care, the Mental Health Centers, special school-based learning programs and charitable organizations, such as the Salvation Army and churches for referral of clients for additional

services. The project also had special contractual arrangements with a private counseling agency.

The major change in Earl K. Long Hospital's service since the Center began was a reduction in the length of stay (from three to four weeks to less than one week) for abused and neglected children admitted without a medical diagnosis for lack of outside placement possibilities. This was due to the development of two emergency shelter care homes, a few more foster care homes, the concerted efforts on the part of the project staff to find relative placements as soon as possible, and the reduction of the number of available beds at the Hospital.

With the project's inception, the Family Court's Probation Department no longer received reports or provided services for abuse and neglect cases. Instead, the Court began acting only in the capacity of holding hearings on cases which require Court involvement, that is, change of custody cases or cases which the social workers believe should have court supervision. Other legal changes in the abuse/neglect system have been: (1) an increase in the number of private or legal aid attorneys in court cases (the project itself contracted for an attorney to regularly consult with its social workers on all court-involved cases); (2) a requirement that only the District Attorney's office (and not the Probation Department) could file petitions on abuse cases; and (3) the development of a procedure whereby judges set specific follow-up dates for review of progress on cases.

After the project began, the Sheriff's Department Child Abuse Team continued to be the key child abuse/neglect investigator among the parish law enforcement agencies. The Center and Protective Services almost always called in the Child Abuse Team to accompany them in dangerous situations

or when a child had to be removed. It was felt that the local police departments, which sometimes must respond to abuse calls, were still not as sensitized to the handling of abuse cases as the Sheriff's Department. The Sheriff's Department also came to rely on the project to a great extent for joint intervention of abuse reports. The Child Abuse Team was dissolved in late 1975, but one of the deputies continued to function as the liaison on abuse calls.

The provision of in-service education to several schools by the project brought school personnel in more contact with the abuse/neglect system. The School Board adopted a policy to facilitate the handling of abuse and neglect by ensuring that the appropriate visiting teacher was called in on all suspected cases; he or she then reported to either the Center or Protective Services.

Caseload Size and Case Outcomes

Table 3 illustrates reporting changes in four agencies which are part of the abuse/neglect system. By extrapolating the Center's five month experience in 1974 to a full year (66 to 158) it is clear that the volume of reports to the project jumped considerably from 1974 to 1975. The effects of the project's extensive public education were felt. The drop in reports to the Center in 1976 might be partially explained by the increase in reporting to Protective Services Unit during that year when the Unit began handling all neglect cases (for part of 1975, the project accepted neglect cases). Another possible explanation is that with the severe staff shortage in early 1976, the project was not able to maintain its high intensity public education effort and community awareness of child abuse and reporting responsibilities diminished.

The increase in reports from 1974 to 1975 to Earl K. Long Hospital was most likely due to its affiliation and working relationship with the project; the project social workers brought all cases of abuse or neglect needing medical examination to the Hospital, whereas before reports were received from Hospital personnel identifying cases in the emergency room or in clinics. The slight decline in reports from the Hospital between 1975 and 1976 probably reflects the project's corresponding decrease in incoming referrals.

Table 3

Volume of Reports: East Baton Rouge Parish

Agency	Number of Reports								
	Abuse			Neglect			Total		
	1974	1975	1976	1974	1975	1976	1974	1975	1976
Child Protection Center	25[a]	187	171	41[a]	61	9	66	248	180
Protective Services	26[b]	4	0	60[b]	100	168	86	104	168
Earl K. Long Hospital	44	100	127	19	65	15	63	165	142
Sheriff's Department	53[b]	42	22	110[b]	37	26	163	79	48

[a]Data since Center opened, August-December 1974.

[b]Figure extrapolated based on actual data for January-October 1974.

There are two probable reasons for the sharp drop in Sheriff's Department reports. First, the project, through its publicity efforts over the course of three years, spread the word that people should report to it rather than the customary sources, either the Family Court or law enforcement. Secondly, the Child Abuse Team in the Sheriff's Department, which

was alert to abuse and neglect situations, was disbanded in late 1975, leading to a decrease in awareness of the problem among the juvenile officers. This meant that fewer cases were identified as either abuse or neglect.

Table 4 illustrates referral sources of all abuse and neglect reports (substantiated and unsubstantiated) to the project, Protective Services and the Sheriff's Department. Whereas there were 126 more abuse and neglect reports community-wide in 1975 and a drop of 35 in 1976, the sources of reports remained quite consistent. Some minor changes included an increase in reports from law enforcement agencies, more cases identified from within the Division of Family Services, and a moderate decline in reporting from relatives.

Cases reported to either Protective Services or to the project could be handled with or without Court involvement. Data on cases that were brought to the Family Court showed that 43 abuse or neglect hearings were held during 1975 and 42 such hearings were held in 1976. While there were no data for 1974 or before against which to make comparisons, personnel at the Court believed that since the project's inception there were more formal hearings called, rather than the previous method of informal hearings in the judges' chambers.

Table 4

Source of Child Abuse/Neglect Reports: East Baton Rouge Parish

Source of Reports	Agency Reported to: Child Protection Center			Protective Services			Sheriff's Department			Total to the Three Agencies: 1974		1975		1976	
	1974[a]	1975	1976	1974[b]	1975	1976	1974[b]	1975	1976	Number	%	Number	%	Number	%
Division of Family Services	13	15	8	14	14	29	0	1	14	27	9	30	7	51	13
Physicians	1	4	3	3	0	0	7	0	0	11	3	4	1	3	1
Hospitals	8	35	25	8	5	13	7	4	0	23	7	45	10	38	9
Law enforcement	7	26	17	3	5	16	2	2	2	12	4	33	8	35	9
Schools	12	32	35	6	5	10	11	7	1	29	9	44	10	46	12
Court	3	6	1	1	1	1	5	0	0	9	3	7	2	2	.5
Other agency	0	0	0	0	3	4	3	3	0	6	2	7	2	1	0
Spouse	3	19	21	3	5	19	31	11	5	37	12	35	8	45	11
Sibling	0	1	0	0	3	0	0	3	0	0	0	7	2	0	0
Relative	13	44	27	20	29	34	44	11	5	77	24	84	20	66	17
Acquaintance/neighbor	3	38	23	9	13	20	38	14	17	50	16	65	15	60	15
Anonymous	2	13	9	5	16	19	15	19	3	22	7	38	9	31	8
Self-referral	0	9	2	10	0	0	0	0	0	10	3	9	2	2	.5
Other	1	5	9	0	4	6	0	0	1	1	.5	9	2	16	4
Unknown	0	0	0	1	0	0	0	14	0	1	.5	14	3	0	0
Total	66	248	180	86	104	168	163	79	48	315	100	431	100	396	100

[a]Center opened, August 1974.

[b]Referral source figures extrapolated from actual data collected for January-October 1974.

III.46

For out-of-home placements, cases which the Court must act upon (handled without a formal hearing, however, if all parties agree), the figures as seen in Table 5 show little difference in the number of children placed between 1974 and 1975, but a dramatic increase in placements in 1976. Given that the total number of abuse and neglect reports to the project and Protective Services (the agencies which recommend placement) stayed almost the same between 1975 and 1976 (352 and 348, respectively), it appears that an explanation of this phenomenon is two-fold. More foster care and emergency shelter slots were available in the community and, therefore, children who needed out-of-home placement could be accomodated, whereas before they could not. Further, there seemed to be an emphasis on the part of the project and Protective Services staffs to advocate out-of-home placements as a solution of choice rather than other modes of intervention and, with the increase in available placement slots, the staff were able to place more children outside the home than previously.

Table 5

Foster Care Placement: East Baton Rouge Parish

	1974	1975	1976
Number of abused/neglected children placed in foster care	63	69	138
Number of abused/neglected children placed since beginning of year who are returned home	40	25	77
Percentage of abused/neglected children placed since beginning of year who are returned home	63%	36%	56%

Legislation

The project's primary legislative effort was in the area of revising the state's termination of parental rights law. A subcommittee of the Center Advisory Board, headed by a consulting attorney who was under contract to the project, worked diligently in attempting to loosen up the very restrictive law, which made it almost impossible to terminate parental rights. In mid-1975 the state legislature passed the new law, which outlined specific steps and time limits for moving toward terminating rights of those natural parents who show no interest in their children's well-being.

Community Resources

Overall, since the project's inception, there was a general decrease in the number of staff in other key abuse and neglect agencies. Prior to federal funding of the Center, Earl K. Long Hospital had a Child Trauma Team which handled the assessment and disposition of hospital-based abuse and neglect cases. In addition, the Hospital social workers provided social work counseling to identified abuse/neglect cases in inpatient and outpatient treatment. With the advent of the project, a new staff pediatrician was hired jointly with the Center, to spend half-time directly on abuse and neglect cases. With the development of a successful working relationship between the project and the Hospital, the Trauma Team was disbanded since it duplicated the Center's work.

The Family Court had 17 probation officers spending approximately 10% of their time managing and providing services to abuse and neglect cases prior to the implementation of the project. When the Center began and the Probation Department ended its involvement in handling these types of cases, the number of staff actually working with abuse and neglect cases

in addition to the judges and their staff was reduced to three intake workers who prepared neglect petitions. In 1976 it was decided that these intake workers could no longer legally prepare neglect petitions and today no probation officers work directly on abuse and neglect cases.

Prior to the project's development, the Sheriff Department's Juvenile Division had implemented a Child Abuse Team to coordinate all abuse and neglect investigations. For both internal political reasons and because the members of the team were either transferred or on leave, the Team stopped functioning in the fall of 1975.

There are two major exceptions in the general reduction of community agencies' staff for abuse/neglect cases. First, the Protective Services staff almost doubled -- from three workers plus a supervisor in 1974 to six workers plus a supervisor in the spring of 1975. This staff increase was due directly to pressure from the project to divide intake and case management responsibilities with Protective Services after it was discovered that there was too great a workload for the Center staff alone. Second, the District Attorney's Office set up a special abuse/neglect section. One attorney was designated to handle these cases, including the preparation of all petitions.

The new abuse and neglect services available in the Baton Rouge community since the beginning of the demonstration have been either directly implemented or supported by the project. A full-time homemaker was on the Center staff and 24-hour crisis intervention was provided by project social workers to suspected abuse and neglect cases or to clients receiving ongoing services. Medical care began to be delivered to all reported abused and neglected children and two emergency shelter care facilities to accomodate

children over two years of age who have to be removed immediately from their dangerous home environments were opened.

Community System Coordination

Of all the meetings attended by project staff in the course of the project's three years for the purpose of promoting community coordination of agencies and services, over 65% were with a variety of agencies in the community which also identify or provide services to abuse and neglect families, such as schools, law enforcement agencies, hospitals, the Family Court, the District Attorney's Office, and 4-C's. Almost 20% of all coordination-related meetings were held with the Division of Family Services, either with the state office or with the local Protective Services Unit. The remaining staff time on coordination activities was spent with legislators or with community-wide resource planning groups.

Another focus of the Center's coordination activity was its Advisory Board. The Board members put in innumerable hours attending meetings and lobbying for community awareness regarding the needs of abused and neglected children and their parents.

Prior to the project's beginning in mid-1974, the East Baton Rouge Parish agencies which were part of the abuse/neglect system had made some formal collaborative agreements among themselves for greater efficiency in handling cases. The Division of Family Services had made referral arrangements with both Earl K. Long Hospital and the Mental Health Centers, and had developed a division of abuse and neglect intake and service responsibilities with the Family Court. The Court had also developed procedural agreements with the School Board, the Sheriff's Department and Earl K. Long Hospital, while local Mental Health Centers had worked out

a referral mechanism with the School Board.

However, the project succeeded in further coordinating the service delivery system in Baton Rouge by means of new collaborative arrangements with a variety of agencies. Table 6 illustrates the formal ties established.

Table 6

Child Protection Center Formal Collaborative Agreements

With Division of Family Services, Protective Services Unit	--Division of abuse and neglect casework responsibilities
With Earl K. Long Hospital	--Sharing a staff position (project's pediatrician half-time at the Hospital
	--Procedures for referral to Hospital emergency room
	--Arrangements for project staff to handle all social work on hospitalized abuse cases
With Family Court	--Procedures regarding hold orders
With Sheriff's Department	--Joint investigation procedures
With School Board	--Referral and case feedback procecures
With Mental Health Centers	--Referral and case feedback procedures
With Family Counseling Services	--Purchase of services

Education and Public Awareness

Personnel in the parish abuse/neglect service agencies all believed that both the professional and lay communities were more aware of the child abuse and neglect and what was being done about it than when the Center began its work. Other agencies' staff members contributed to some degree

to this overall increase in knowledge about child abuse and neglect, however, most of the increase in community awareness could be attributed to the concerted effort of the project staff itself. The project had a full-time public education specialist whose task it was to coordinate the dissemination of information to the general public. This was accomplished through the use of all aspects of the mass media, and by talks and audio-visual presentations. Other Center staff, primarily the director, also made presentations on abuse and neglect and the project's role in the system. During the last demonstration year (1976-1977) a team made up of the project pediatrician, the project director, a staff social worker, the public education specialist and a legal consultant visited several schools and other community groups to make presentations.

Over the course of the three year demonstration period, approximately 25% of all educational presentations were made to students; another 25% were to community groups, such as civic and religious organizations. School personnel and law enforcement staffs also made up a significant percentage of the total audience of Center education. The major public education to the ongoing educational activities was a three-day workshop in the spring of 1975 for Baton Rouge professionals.

XII. RESOURCE ALLOCATION AND SERVICE VOLUME AND COSTS

This section of the case study is based on data from three sample months during one year (October 1975, April 1976 and October 1976). Staff time per service, including donated time, and budget allocations per service were collected. It is estimated that the Baton Rouge project staff and consultants put in 20,600 hours over a year's time; this equaled a 9.9 person-year effort, with an average annual budget of $175,500.

For the client-related services, 27% of the time went into ongoing case management and review activities, 8% went into intake and 6% was put into homemaking. Coordination activities and professional and community education consumed 12% of staff time. Staff development and training activities took up 8% of the time, and general management used, on average, 18% of the time.

Budget expenses generally reflect the allocation of staff time, with some noticeable exceptions. Whereas case management took 27% of staff time, it used only 19% of the budget. On the other hand, general management used up 27% of the budget compared to 18% of the time, and medical care consumed 8% of the budget for only 2% of the total staff time. Both general management and medical care used proportionately large amounts of very expensive time (a physician and a large percentage of the project director) while case management used up comparatively less expensive time (social workers and a high percentage of typists' time to keep up the case records).

On average the project staff together did 27 intakes per month and maintained an active caseload of 83 per month. Fifty-two individual counseling contacts were made in a given month, which works out to less than one (0.6) per month per case. Many crisis intervention contacts were also made in an average month -- 16 such contacts for clients in intake and 21 for clients in the active caseload. Other notable monthly outputs included six multidisciplinary reviews (one to two at each of the weekly meetings of the team), 20 homemaking contacts (about one per working day per month), and 21 medical visits (again, about one per day). The average of 19 rides provided per month cannot be considered typical, because it is the result of 40 rides provided in October 1975 when the project had an active volunteer component to a low of three in October 1976.

Table 7 displays two unit cost figures; one based on actual budget dollars per unit of service delivered, the other based on "social dollars," or actual budget dollars plus a dollar value for donated time and resources (e.g., volunteers, including students, and consultants who were reimbursed at less than their going rate). In general, there were only minimal differences between the two figures for the Center, due to a relatively limited volunteer component. Most of the differences between the two unit costs for direct client services are accounted for by a social work student who worked at the project for her placement.

In actual dollars, an intake cost the project $36.54 per month and carrying one case cost $35.22 per month. Some of the more expensive services were court case activities, which cost $175.40 per case (this included the use of a consulting lawyer), multidisciplinary team reviews at $67.63 per review (many staff and consultants met to review only a limited number of cases), and medical care at $90.48 per visit (this suggests under-utilizing the staff physician who was paid a flat rate regardless of the number of children brought in). The homemaking unit cost might seem high ($21.46), but it must be pointed out that a typical homemaking contact for the project most often included the better part of one day.

Table 7: Project Resource Allocation and Service Costs

Activity	Resource Allocation to Activities		Volume and Unit Costs of Services		
	Average Annual Time Allocation	Average Annual Budget Allocation	Average Monthly Volume	Average Annual Unit Cost	Average Unit Cost to Community
Community Education	3%	3%			
Professional Education	6	5			
Coordination	3	3			
Staff Development/Training	8	7			
Program Planning/Development	1	1			
General Management	18	27			
Project Research	1	1			
BPA Evaluation	2	2			
Outreach	--	--	3 cases	$12.85	$16.98
Intake/Initial Diagnosis	8	6	27 intakes	36.54	40.54
Case Management Review	27	19	83 average caseload	35.22	36.99
Court Case Activities	2	3	3 cases	175.40	175.40
Crisis Intervention During Intake	2	2	16 contacts	7.83	7.83
Multidisciplinary Team Review	2	3	6 reviews	67.63	71.30
Individual Counseling	3	2	52 contacts	4.98	5.69
Couples Counseling[a]	--	--	14 contacts	3.75	3.75
Family Counseling	--	--	10 contacts	11.11	11.11
Individual Therapy[a]	--	--	16 contacts	9.84	9.84
Crisis Intervention After Intake	1	2	21 contacts	5.16	5.16
Homemaking	6	3	20 contacts	21.46	21.46
Medical Care	2	8	21 visits	90.48	90.48
Babysitting/Child Care[a]	3	2	110 child-hours	1.06	1.06
Transportation/Waiting	2	1	19 rides	17.45	19.04
Psychological/Other Testing	--	--	6 person-tests	32.50	32.50
Follow-Up	--	--	4 person follow-ups	11.92	11.92
Total Annual Person Years/Budget	9.9	$175,524	Average Monthly Caseload = 83		

[a]Averages based on data from October 1975 and April 1976 only; these services were not provided in October 1976.